MARC ZIMBLER, MD, FACS
FACIAL PLASTIC & RECONSTRUCTIVE SURGERY

Patient Registration

Patient Information

Last Name:_____ First Name:_____

Birth Date: _____/_____/_____ Age:_____ Gender: ☐M ☐F Marital Status: ☐S ☐M ☐W ☐D

SS# :_____-_____-_____

Address:_____

City:_____ State: _____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Would You Like to Receive Periodic Emails About New Technologies or Upcoming Events? ☐ Yes ☐ No

Emergency Contact:_____ Phone Number:_____

Primary Physician Name:_____

Who should we thank for referring you?_____

Purpose of Today's Visit_____

Employer Information

Occupation:_____ Work Number:_____

Company Name:_____

Address:_____

Medical Insurance Information

Primary Insurance:_____

Relationship of Insured to Guarantor:_____

Guarantor Name:_____

Secondary Insurance:_____

I hereby authorize payment directly to Dr. Marc S. Zimbler for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by my insurance and for all services rendered on my behalf or my dependents.

I authorize Dr. Marc S. Zimbler and/or any provider or supplier of services in his office to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party:_____ Date:____/____/_____

990 FIFTH AVENUE NEW YORK, NY 10075 212.570.9900

Medical History Questionnaire

Place checks if you have any of the following medical conditions:

- ☐ Hypertension:
- ☐ High Cholesterol:
- ☐ Irregular Heart Rhythm / Atrial Fibrillation:
- ☐ Heart Disease / Heart Attack:
- ☐ Stent Placement:
- ☐ Mitral Valve Prolapse:
- ☐ Peripheral Vascular Disease / Aortic Stenosis / Aortic Aneurysm:

- ☐ Lung Disease / Asthma / Tuberculosis:
- ☐ Sleep Apnea:

- ☐ History of Cancer:
- ☐ Neurologic Disease / Migraines / Stroke:
- ☐ Arthritis / Joint Disease:
- ☐ Autoimmune Disease:
- ☐ GI Problems / Stomach Ulcers / IBS:
- ☐ Kidney Disorder:
- ☐ Diabetes:
- ☐ Thyroid Dysfunction:
- ☐ Dry Eye / Eye Disease / Glaucoma:
- ☐ Spinal or Back Disorders:

- ☐ Previous Blot Clots or Thrombophlebitis:
- ☐ Bleeding Disorders / Anemia / Blood Disease:
- ☐ Are You Taking Blood Thinners:
- ☐ Blood Transfusions:
- ☐ Liver Disease:
- ☐ Hepatitis or Cirrhosis:
- ☐ AIDS or HIV:

- ☐ History of Skin Cancer:
- ☐ Skin Disease (Herpes, Cold Sores, Eczema, Psoriasis):
- ☐ Have You Used Accutane in the Last 12 Months:
- ☐ Unusual Scarring or Keliod Formation:
- ☐ Facial Paralysis or Bell's Palsy:
- ☐ Radiation Therapy to the Head or Neck:
- ☐ Have You Ever Had a Serious Injury To Your Head, Face or Neck:
- ☐ Is There a History of Nasal Trauma:
- ☐ Difficulty Breathing Through Your Nose / Sinusitis:

- ☐ Depression or Anxiety:
- ☐ Other Psychiatric Illness:
- ☐ Family Medical History of Significance:
- ☐ Do You Suspect You Might Be Pregnant:
- ☐ Are You Pre-treated With Antibiotics By Your Dentist:
- ☐ Other Medical Conditions (Please Elaborate):

Place checks if you have any of the following medical conditions:

Past Surgical History:

☐ Have you used Botox or other facial fillers within the last 12 months:_____
☐ History of facial cosmetic surgery (nose / eyelid / facelift):_____
☐ History of functional nasal or sinus injury:_____
☐ History of any other surgeries:_____

Allergies:

☐ Allergies to medications:_____
☐ Allergies to adhesive tape:_____
☐ Allergies to local anesthesia / Lidocaine:_____
☐ Allergies or family history of allergy to general anesthesia:_____
☐ Other allergies:_____

Social History:

☐ Do you currently smoke:_____
☐ Have you ever smoked in the past:_____
☐ Do you drink more than 2 alcoholic drinks per day:_____
☐ Have you ever had a problem with alcohol dependence:_____
☐ Have you ever had a problem with drug dependence:_____
☐ Do you use any "recreational drugs" with frequency:_____

Please list all medications: (include aspirin, birth control, vitamins, herbal or homeopathic medicines)

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Consent for Photography

I do hereby voluntarily give consent to the taking of photographs of me under the following conditions:

1. The photographs may be released to other physicians or insurance companies when necessary.

2. The photographs will be used for medical records and may be published in medical professional journals or medical books, or used for other purposes which may be deemed proper in the interest and advancement of medical knowledge, medical education - research, or patent education.

3. **The photographs will not be available on the internet** (unless published in professional medical journals which have on-line journal access).

4. Although I give permission to the publication and use of details concerning my case, it is specifically understood that I will not be identified by name.

_____ _____/_____/_____
Signature (Patient or Guardian) Date

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Notice of Privacy Practice
Patient Acknowledgement

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practices legal duties with respect to my health information. All forms and policies referred to in this Notice of Privacy Practices are available at the reception desk and in the waiting room.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information it maintains. If changes occur, this practice will provide me a revised notice upon request.

Patient Name:_____

Date of Birth:____/____/_____

Signature:_____

Today's Date: ____/____/_____

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Letter of Agreement Regarding Medical Insurance

This letter of agreement acknowledges that you are aware that Dr. Zimbler is not a participator with insurance plans (except Medicare). As a courtesy, we will submit your bill directly to your insurance carrier. Any portion of the bill not covered by insurance, i.e. deductibles/co-payments, will be your responsibility.

By signing this letter you agree to send our office any payments/documents sent directly to you by your insurance carrier. If you have questions regarding your insurance plan, make sure this is discussed with our office before services are rendered.

Sign:_____

Date: _____/_____/_____

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